

accordance with 33 CFR 117.687, which states the draws of the bridges across the Missouri River shall open on signal; except during the winter season between the date of closure and date of opening of the commercial navigation season as published by the Army Corps of Engineers, the draws need not open unless at least 24 hours advance notice is given.

There are no alternate routes for vessels transiting this section of the Missouri River. The Harry S. Truman Railroad Drawbridge, in the closed-to-navigation position, provides a vertical clearance of 51.3 feet above zero on W. B. gage at Kansas City, Missouri. Navigation on the waterway consists primarily of commercial tows and recreational watercraft. This temporary deviation has been coordinated with the waterway users.

In accordance with 33 CFR 117.35(e), the drawbridge must return to its regular operating schedule immediately at the end of the effective period of this temporary deviation. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: November 16, 2012.

Eric A. Washburn,

Bridge Administrator, Western Rivers.

[FR Doc. 2012-29444 Filed 12-5-12; 8:45 am]

BILLING CODE 9110-04-P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 51

RIN 2900-AO57

Contracts and Provider Agreements for State Home Nursing Home Care

AGENCY: Department of Veterans Affairs.

ACTION: Interim final rule.

SUMMARY: This interim final rule amends Department of Veterans Affairs (VA) regulations to allow VA to enter into contracts or provider agreements with State homes for the nursing home care of certain disabled veterans. This rulemaking is required to implement a change in law that revises how VA will pay for care provided to these veterans and authorizes VA to use provider agreements to pay for such care. The change made by this law applies to all care provided to these veterans in State homes on and after February 2, 2013.

DATES: *Effective Date:* This interim final rule is effective on February 2, 2013. Comments must be received by VA on or before February 4, 2013.

ADDRESSES: Written comments may be submitted by email through [http://](http://www.regulations.gov)

www.regulations.gov; by mail or hand-delivery to Director, Regulation Policy and Management (O2REG), Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420; or by fax to (202) 273-9026. (This is not a toll-free number.) Comments should indicate that they are submitted in response to “RIN 2900-AO57—Contracts and Provider Agreements for State Home Nursing Home Care.” Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461-4902 for an appointment. (This is not a toll-free number.) In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at <http://www.regulations.gov>.

FOR FURTHER INFORMATION CONTACT:

Kelly Schneider, State Home Per Diem Program Manager, Purchased Care (10NB3), Chief Business Office, Veterans Health Administration, 810 Vermont Avenue NW., Washington, DC 20420. Please call (308) 389-5106. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: This rulemaking implements VA’s authority to pay for State home nursing home care under section 105 of the Honoring America’s Veterans and Caring for Camp Lejeune Families Act of 2012 (the Act), Public Law 112-154, 126 Stat. 1165, which was enacted on August 6, 2012.

VA pays State veterans homes to provide nursing home care to eligible veterans under 38 U.S.C. 1741 and 1745. Under 38 U.S.C. 1745, as it existed before it was amended by section 105 of the Act, and current 38 CFR 51.41, VA currently pays State homes a special daily per diem rate for care provided to the following veterans: Those who need nursing home care for a service-connected disability, and those who need nursing home care and have either a service-connected disability rating of 70 percent or more or a rating of total disability based on individual unemployability. These payments under current 38 CFR 51.41 are considered grant payments. Section 105 of the Act requires VA to change the mechanism for paying State homes for care provided to these veterans. Specifically, as of February 2, 2013, VA will only be authorized to use contracts or provider agreements to pay State homes for the nursing home care of these veterans. This rulemaking therefore will revise VA’s regulation at 38 CFR 51.41, effective February 2, 2013, to implement

VA’s authority under the Act to enter into provider agreements and contracts to pay for this care.

In § 51.41(a), as revised by this rulemaking (hereinafter referred to as “revised § 51.41”), we identify the veterans whose care is affected by this rulemaking, i.e., veterans residing in State homes who need nursing home care for a VA adjudicated service-connected disability, or who need nursing home care and have either: (1) A singular or combined rating of 70 percent or more based on one or more service-connected disability, or (2) a rating of total disability based on individual unemployability. These veterans are identified by statute and are the same veterans for whose care State homes are currently paid the special daily per diem rate. 38 U.S.C. 1745(a)(1)(A) and (B). This rulemaking will affect payments for State nursing home care only for these veterans. VA will continue to pay basic per diem as specified in 38 CFR part 51 for all other veterans receiving State home nursing home care.

Consistent with current practice, if a veteran receives a retroactive VA service-connected disability rating and becomes a veteran identified in revised § 51.41(a), the State home may request additional payment for care rendered prior to the rating. Revised § 51.41(c)(4) provides that in these instances the State home may request payment under the VA provider agreement for care back to the retroactive effective date or February 2, 2013, whichever is later. For care provided to a veteran before February 2, 2013, the State home may request payment at the special per diem rate in effect at the time that the care was rendered, which will be reimbursed based on VA’s special per diem authority in current § 51.41. VA cannot enter into a contract to make retroactive payments for care rendered in the past. This is because contracts can only be created for a bona fide need that exists at the time of contract execution, not one that may have existed in the past.

Revised § 51.41(a) states that VA and State homes may enter into both contracts and provider agreements, but each veteran’s care will be paid through only one of these two instruments. This allows VA and State homes to use the payment instrument that best meets their needs.

As noted above, section 105 of the Act specifies that VA must pay State homes for the nursing home care of these veterans using either contracts or provider agreements. Because the Act makes no further explanation of the term “contracts,” VA has determined that existing contracting authorities

should apply in this regulation. Contracts between VA and State homes are currently negotiated under Federal contract statutes and regulations, including the Federal Acquisition Regulation, which is set forth at 48 CFR chapter 1, and VA Acquisition Regulations, which are set forth at 48 CFR chapter 8.

Paragraph (b) of revised § 51.41 discusses contracts. The Act requires that rates of payments be “based on a methodology, developed by the Secretary in consultation with the State home, to adequately reimburse the State home for the care provided.” Pub. L. 112–154, Sec. 105(a)(2). Contracts are negotiated with each State home, as stated in revised § 51.41(b)(1). Additionally, the Act requires that VA offer, at the request of the State home, to provide either a contract or provider agreement that “reflects the overall methodology of reimbursement for such care that was in effect for such state home on the day before the date of enactment of this Act.” Pub. L. 112–154, Sec. 105(c)(2). This mandate is stated in revised § 51.41(b)(2).

Revised § 51.41(c) sets forth VA’s authority to enter into provider agreements for State nursing home care. Under 38 U.S.C. 1745(a)(1), as amended by section 105 of the Act, VA is authorized to enter into an agreement under 38 U.S.C. 1720(c)(1) with each State home for nursing home care. Section 1720(c)(1) authorizes VA to enter into agreements with non-VA providers using “the procedures available for entering into provider agreements under section 1866(a) of the Social Security Act.” Section 1866(a) (codified at 42 U.S.C. 1395cc(a)) authorizes the Department of Health and Human Services to enter into agreements with participating Medicare providers, and specifies the rates and terms of those agreements. Similar agreements are offered under State Medicaid programs. Agreements under both Medicare and State Medicaid programs are administered by the Centers for Medicare and Medicaid Services (CMS).

Pursuant to the Act, this rulemaking implements VA’s authority in section 1720(c)(1) to enter into provider agreements with State homes to provide care to the veterans covered by the Act. VA provider agreements with State homes will be entered into using procedures similar to those used in entering into Medicare agreements. VA provider agreements will accommodate the differences between VA’s State home programs and Medicare programs and enable participation in VA provider agreements by all State homes.

The rates of payment for VA provider agreements are reflected in revised § 51.41(c)(1), and the procedures and standards of care are covered in revised § 51.41(c)(3).

Revised § 51.41(c)(1) establishes payment rates for VA provider agreements by adopting part of VA’s existing payment methodology for State homes providing care to veterans affected by the Act. For VA provider agreements, we have adopted VA’s rate calculation from current § 51.41(b)(1), which is commonly called the “prevailing Medicare rate” (“prevailing rate”). The prevailing rate is specific to each State home, and is based on an average of CMS case-level data in the geographic area, labor costs, and physician’s fees. Under provider agreements, VA will pay each State home the prevailing rate for the veterans under their care each day. By contrast, under a Medicare or State Medicaid agreement, the State home would be paid an amount determined by a CMS rate schedule specific to each resident, based on an assessment of their medical conditions and the amount of care the resident would require. We have amended the prevailing rate regulation in § 51.41(c) to make it clearer and easier to understand how the rates are calculated, but the method used for calculating the rates remains the same.

There are strong administrative reasons to support using the prevailing rate to pay for care provided to veterans by State nursing homes. Foremost, using a single, fixed rate will provide regular and predictable payment amounts, which will make administration of the program easier both for VA and for State homes. Second, the prevailing rate is familiar to State veterans homes, as it has been one of two payment methodologies that have been effective in VA regulations since May 29, 2009. It is also familiar to VA for the same reasons, which will make it easy to implement as a payment rate in the short period of time required by statute (i.e., on and after February 2, 2013). In addition, some State homes—particularly the approximately 40 percent of State homes that are not CMS certified—are unfamiliar with the process of determining an appropriate individualized rate using the CMS fee schedule. Moreover, these rates must be adjusted whenever the veteran’s level of care adjusts, which means that the same veteran might be subject to several different rates during any one calendar month. These frequent calculations and recalculations would be particularly burdensome on State homes that lack current administrative mechanisms to perform them, but would also present a

significant strain on VA’s ability to effectively administer payments and ensure that payments are correct. Moreover, the prevailing rate methodology should not, over time, deviate from the amount that payment would be using the Medicare fee schedule. The prevailing rate is based on CMS data, therefore it is a close reflection of the payments State homes would receive if CMS rates were used. Finally, VA has received comments from State homes and groups representing the State homes that they would prefer to receive the prevailing rate.

Under this rule, the VA provider agreement payment mechanism presents an option to pay for State home care that is distinct from contracting. Apart from the distinct terminology difference, using the prevailing rate, which is based on the non-negotiable Medicare fee schedule (or State Medicaid payment system), does not permit rate negotiation. In this manner, provider agreements are not contractual in nature. Allowing VA and State homes to negotiate rates would make the agreements subject to the authorities applicable to negotiated contracts, which is contrary to Congressional intent.

Revised § 51.41(c)(2) requires that the provider agreement reflect that State homes may not charge any individual, insurer, or entity other than VA for nursing home care paid for by VA under a VA provider agreement. A similar requirement is in current § 51.41(c), and the basis for the requirement that payment under an agreement must represent payment in full is not affected by the amendments made by the Act. The purpose of this paragraph, consistent with the purpose of the current paragraph, is to ensure that VA does not pay for services—such as drugs or medical care—that should be provided by the State home as part of the home’s care for the veteran. It is also to ensure that VA does not pay for care that is covered by another responsible party.

Revised § 51.41(c)(3) states that provider agreements are subject to the rest of 38 CFR part 51, unless part 51 conflicts with paragraph (c). It also states that the term “per diem” in part 51 includes payments under provider agreements for the purposes of this section. This provision will ensure that State homes are subject to VA’s requirements such as recognition and certification, standards of care, enforcement of such standards, etc, in the same manner as they are currently. Nothing in the Act suggests that these procedures and standards should not

apply to State homes to which we will pay for care via a provider agreement. Moreover, State homes are familiar with our existing procedures and standards and will also need to continue to comply with them in order to receive VA basic per diem payments for providing nursing home care to veterans who are not subject to this rulemaking. Revised 51.41(c)(4) describes procedures for payments if a veteran receives a retroactive VA service-connected disability rating, as discussed previously.

Revised paragraph (d) requires that the Director of the VA medical center of jurisdiction or a designee sign VA provider agreements.

Revised § 51.41(e) requires a State home to submit a VA Form 10–10EZ, Application for Medical Benefits (or VA Form 10–10EZR, Health Benefits Renewal Form), and VA Form 10–10SH, State Home Program Application for Care—Medical Certification, to the VA medical center of jurisdiction prior to entering into a VA provider agreement for the veterans for whom the State home will seek payment under the provider agreement. These VA forms are currently submitted by a new State home or when a State home seeks payment for providing care to a new veteran in the State home. VA must collect these forms from States seeking to enter into provider agreements to assist with administering the change from the current per diem payment program to provider agreements. Revised § 51.41(e) also requires that State homes with a VA provider agreement follow § 51.43(a) regarding submission of required forms for payments.

Revised paragraph (f) sets forth procedures to terminate provider agreements. A State home can terminate the agreement by sending VA written notice of its intent to terminate the agreement 30 days in advance of the termination date under paragraph (f)(1). This provision is consistent with the transfer and discharge rights of veterans stated in § 51.80. It is important to ensure that VA has advance notice of any termination that might cause a disruption in care for veterans, and also because State homes may choose to contract with VA to provide care, rather than continue to provide care under a provider agreement. Under paragraph (f)(2), a VA provider agreement will terminate immediately upon a final determination that the State home has lost VA recognition under 38 CFR 51.30. This provision is substantively consistent with current State home per diem payment procedures at §§ 51.10 and 51.30(f).

Revised § 51.41(g) says that under these provider agreements, State homes need not comply with the Service Contract Act of 1965 (codified at 41 U.S.C. 351, et seq.). While the Service Contract Act of 1965 applies to contracts entered into by the United States for services by service employees, it does not apply to Medicare provider agreements because these are not contracts with the United States. This is consistent with VA's recent interpretation of its provider agreement authority under 38 U.S.C. 1720(c)(1) in RIN 2900–AO15, in which we explain that VA provider agreements are not contracts. VA provider agreements are based on the non-negotiable Medicare fee schedule (or State Medicaid payment system), which does not permit rate negotiation. In this manner, provider agreements are not contractual in nature. VA believes it is reasonable to apply this interpretation to all VA provider agreements because their purpose and execution is the same. However, paragraph (g) would require that providers comply with all other applicable Federal laws concerning employment and hiring practices, including the Fair Labor Standards Act, National Labor Relations Act, the Civil Rights Acts, the Age Discrimination in Employment Act of 1967, the Vocational Rehabilitation Act of 1973, Worker Adjustment and Retraining Notification Act, Sarbanes-Oxley Act of 2002, Occupational Health and Safety Act of 1970, Immigration Reform and Control Act of 1986, Consolidated Omnibus Reconciliation Act, the Family and Medical Leave Act, the Americans with Disabilities Act, the Uniformed Services Employment and Reemployment Rights Act, the Immigration and Nationality Act, the Consumer Credit Protection Act, the Employee Polygraph Protection Act, and the Employee Retirement Income Security Act.

The Act requires VA to consult with State homes to develop the payment methodology under these authorities. During development of this rulemaking, groups representing State veterans homes, such as the National Association of State Veterans Homes and the National Association of State Directors of Veterans Affairs, and State officials on their own wrote to VA and spoke with VA representatives about implementing the Act and provided comments about payment methodologies under contracts and provider agreements. In addition to these discussions and submissions, contracts are negotiated with each State home, and that negotiation will provide the opportunity for individualized

consultation. The comment period for this notice also serves as part of the consultation process for payments under provider agreements. VA welcomes further comment from the public, particularly those who will be affected by this regulation, to ensure we implement the new payment methodology required by the Act effectively.

Administrative Procedure Act

The Secretary of Veterans Affairs finds that there is good cause under 5 U.S.C. 553(b)(B) to publish this rule without prior opportunity for public comment. This interim final rule is necessary to implement the contracting and provider agreement authority of section 105 of the Act, which requires VA to change its payment methodology for State home nursing home care of severely disabled Veterans. This rule must be in place by February 2, 2013, in order to ensure continuity of care for affected veterans in State veterans nursing homes. As of February 2, 2013, VA will no longer have authority to use its current procedures to pay State homes for care provided to the affected veterans, and must enter into either contracts or provider agreements with State homes by that date. VA presently has the authority to enter into contracts with State homes on that date, but many State homes have notified VA that some States will be unable to enter into contracts with VA for this care due to the application of many Federal acquisition laws, such as the Service Contract Act of 1965, the applicability of which State governing bodies may not support because the provisions would require greater expenditures by the States. However, VA lacks the authority to enter into provider agreements without this rulemaking. Failure to effect this regulatory change by February 2, 2013, may cause serious disruptions in VA's ability to pay for the care provided to certain veterans in State home nursing homes. For the foregoing reasons, VA is issuing this rule as an interim final rule, effective on February 2, 2013. The Secretary of Veterans Affairs will consider and address comments that are received within 60 days after this interim final rule is published in the **Federal Register**.

Effect of Rulemaking

Title 38 of the Code of Federal Regulations, as revised by this final rulemaking, represents VA's implementation of its legal authority on this subject. Other than future amendments to this regulation or governing statutes, no contrary guidance

or procedures are authorized. All existing or subsequent VA guidance must be read to conform with this rulemaking if possible or, if not possible, such guidance is superseded by this rulemaking.

Paperwork Reduction Act

Although this action contains a provision constituting collections of information at 38 CFR 51.41(e), under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521), no new or proposed revised collections of information are associated with this interim final rule. The information collection requirements for § 51.41(e) are currently approved by the Office of Management and Budget (OMB) and have been assigned OMB control numbers 2900–0091 and 2900–0160.

Regulatory Flexibility Act

The Secretary hereby certifies that this interim final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This interim final rule will directly affect only States and will not directly affect small entities. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604.

Executive Order 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a “significant regulatory action,” requiring review by the Office of Management and Budget (OMB) unless OMB waives such review, as “any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create

a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in this Executive Order.”

VA has examined the economic, interagency, budgetary, legal, and policy implications of this regulatory action, and it has been determined not to be a significant regulatory action under Executive Order 12866.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any one year. This interim final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.015, Veterans State Nursing Home Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; and 64.022, Veterans Home Based Primary Care.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. John R. Gingrich, Chief of Staff, Department of Veterans Affairs, approved this document on December 3, 2012 for publication.

List of Subjects in 38 CFR Part 51

Administrative practice and procedure; Claims; Day care; Dental health; Government contracts; Grant programs—health; Grant programs—

veterans; Health care; Health facilities; Health professions; Health records; Mental health programs; Nursing homes; Reporting and recordkeeping requirements; Travel and transportation expenses; Veterans.

Dated: December 3, 2012.

Robert C. McFetridge,

Director of Regulation Policy and Management, Office of General Counsel, Department of Veterans Affairs.

For the reasons set out in the preamble, VA amends 38 CFR part 51 as follows:

PART 51—PER DIEM FOR NURSING HOME CARE OF VETERANS IN STATE HOMES

■ 1. The authority citation for part 51 continues to read as follows:

Authority: 38 U.S.C. 101, 501, 1710, 1720, 1741–1743; and as stated in specific sections.

■ 2. Revise § 51.41 to read as follows:

§ 51.41 Contracts and provider agreements for certain veterans with service-connected disabilities.

(a) *Contract or VA provider agreement required.* VA and State homes may enter into both contracts and provider agreements. VA will pay for each eligible veteran’s care through either a contract or a provider agreement (called a “VA provider agreement”). Eligible veterans are those who:

(1) Are in need of nursing home care for a VA adjudicated service-connected disability, or

(2) Have a singular or combined rating of 70 percent or more based on one or more service-connected disabilities or a rating of total disability based on individual unemployability and are in need of nursing home care.

(b) *Payments under contracts.*

Contracts under this section will be subject to this part to the extent provided for in the contract and will be governed by federal acquisition law and regulation. Contracts for payment under this section will provide for payment either:

(1) At a rate or rates negotiated between VA and the State home; or

(2) On request from a State home that provided nursing home care on August 5, 2012, for which the State home was eligible for payment under 38 U.S.C. 1745(a)(1), at a rate that reflects the overall methodology of reimbursement for such care that was in effect for the State home on August 5, 2012.

(c) *Payments under VA provider agreements.* (1) State homes must sign an agreement to receive payment from VA for providing care to certain eligible veterans under a VA provider

agreement. VA provider agreements under this section will provide for payments at the rate determined by the following formula. For State Homes in a metropolitan statistical area, use the most recently published CMS Resource Utilization Groups (RUG) case-mix levels for the applicable metropolitan statistical area. For State Homes in a rural area, use the most recently published CMS Skilled Nursing Prospective Payment System case-mix levels for the applicable rural area. To compute the daily rate for each State home, multiply the labor component by the State home wage index for each of the applicable case-mix levels; then add to that amount the non-labor component. Divide the sum of the results of these calculations by the number of applicable case-mix levels. Finally, add to this quotient the amount based on the CMS payment schedule for physician services. The amount for physician services, based on information published by CMS, is the average hourly rate for all physicians, with the rate modified by the applicable urban or rural geographic index for physician work, then multiplied by 12, then divided by the number of days in the year.

Note to paragraph (c)(1): The amount calculated under this formula reflects the prevailing rate payable in the geographic area in which the State home is located for nursing home care furnished in a non-Department nursing home (a public or private institution not under the direct jurisdiction of VA which furnishes nursing home care). Further, the formula for establishing these rates includes CMS information that is published in the **Federal Register** every year and is effective beginning October 1 for the entire fiscal year. Accordingly, VA will adjust the rates annually.

(2) The State home shall not charge any individual, insurer, or entity (other than VA) for the nursing home care paid for by VA under a VA provider agreement. Also, as a condition of receiving payments under paragraph (c) of this section, the State home must agree not to accept drugs and medicines from VA provided under 38 U.S.C. 1712(d) on behalf of veterans covered by this section and corresponding VA regulations (payment under paragraph (c) of this section includes payment for drugs and medicines).

(3) Agreements under paragraph (c) of this section will be subject to this part, except to the extent that this part conflicts with this section. For purposes of this section, the term "per diem" in part 51 includes payments under provider agreements.

(4) If a veteran receives a retroactive VA service-connected disability rating and becomes a veteran identified in paragraph (a) of this section, the State home may request payment under the VA provider agreement for nursing home care back to the retroactive effective date of the rating or February 2, 2013, whichever is later. For care provided after the effective date but before February 2, 2013, the State home may request payment at the special per diem rate that was in effect at the time that the care was rendered.

(d) *VA signing official.* VA provider agreements must be signed by the Director of the VA medical center of jurisdiction or designee.

(e) *Forms.* Prior to entering into a VA provider agreement, State homes must submit to the VA medical center of jurisdiction a completed VA Form 10-10EZ, Application for Medical Benefits (or VA Form 10-10EZR, Health Benefits Renewal Form, if a completed VA Form 10-10EZ is already on file at VA), and a completed VA Form 10-10SH, State Home Program Application for Care—Medical Certification, for the veterans for whom the State home will seek payment under the provider agreement. After VA and the State home have entered into a VA provider agreement, forms for payment must be submitted in accordance with paragraph (a) of this section. VA Forms 10-10EZ and 10-10EZR are set forth in full at § 58.12 of this chapter and VA Form 10-10SH is set forth in full at § 58.13 of this chapter.

(The Office of Management and Budget has approved the information collection requirements in this section under control numbers 2900-0091 and 2900-0160.)

(f) *Termination of VA provider agreements.* (1) A State home that wishes to terminate a VA provider agreement with VA must send written notice of its intent to the Director of the VA medical center of jurisdiction at least 30 days before the effective date of termination of the agreement. The notice shall include the intended date of termination.

(2) VA provider agreements will terminate on the date of a final decision that the home is no longer recognized by VA under § 51.30.

(g) *Compliance with Federal laws.* Under provider agreements entered into under this section, State homes are not required to comply with reporting and auditing requirements imposed under the Service Contract Act of 1965, as amended (41 U.S.C. 351, *et seq.*); however, State homes must comply with all other applicable Federal laws concerning employment and hiring practices including the Fair Labor

Standards Act, National Labor Relations Act, the Civil Rights Acts, the Age Discrimination in Employment Act of 1967, the Vocational Rehabilitation Act of 1973, Worker Adjustment and Retraining Notification Act, Sarbanes-Oxley Act of 2002, Occupational Health and Safety Act of 1970, Immigration Reform and Control Act of 1986, Consolidated Omnibus Reconciliation Act, the Family and Medical Leave Act, the Americans with Disabilities Act, the Uniformed Services Employment and Reemployment Rights Act, the Immigration and Nationality Act, the Consumer Credit Protection Act, the Employee Polygraph Protection Act, and the Employee Retirement Income Security Act.

(Authority: 38 U.S.C. 101, 501, 1710, 1720, 1741-1745; 42 U.S.C. 1395cc)

[FR Doc. 2012-29521 Filed 12-5-12; 8:45 am]

BILLING CODE 8320-01-P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA-R10-OAR-2012-0078; FRL-9722-9]

Approval and Promulgation of State Implementation Plans: State of Washington; Regional Haze State Implementation Plan

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: EPA is taking final action to approve the Best Available Retrofit Technology (BART) determination for NO_x for the TransAlta Centralia Generation LLC coal-fired power plant in Centralia, Washington (TransAlta). The Washington State Department of Ecology (Ecology) submitted its Regional Haze State Implementation Plan (SIP) on December 22, 2010 to meet the requirements of the Clean Air Act Regional Haze Rule at 40 CFR 50.308. On December 29, 2011 Ecology submitted an update to the SIP submittal containing a revised and updated BART determination for TransAlta. On May 23, 2012, EPA proposed to approve the portion of the revised SIP submission containing the BART determination for TransAlta.77 FR 30467. EPA plans to act on the remaining Regional Haze SIP elements for Washington in the near future.

DATES: This action is effective on January 7, 2013.

ADDRESSES: EPA has established a docket for this action under Docket Identification No. EPA-R10-OAR-